CLIENT NAME: ___________________________________ DATE: __________________

Do you have any advance directives, a living will, or a durable power of attorney for health care decisions in place that ELC should be aware of? □ Yes □ No
If yes, please give that information to the Intake Coordinator for placement in your clinical file.
* Information on Advance Directives is available from the Intake Coordinator

Please check the current physical/medical conditions that apply to you today.

___ Not Applicable
___ Developmental Disability.
___ Organically based problem in expressive communication
___ Blindness or severe visual impairment
___ Deafness or severe hearing loss
___ Non-ambulation or major difficulties in ambulation
___ Fibromyalgia
___ Mental retardation
___ Diabetes
___ High blood pressure
___ Immune system suppression
___ Chronic pain
___ Hepatitis
___ M.S.
___ Heart Problems
___ Thyroid Problems
___ Emphysema
___ Cancer
___ Polio
___ Parkinson’s Disease
___ Tuberculosis
___ Cirrhosis
___ Alzheimer’s Disease
___ Korsakoff’s Syndrome
___ Stroke
___ Leukemia
___ Other Chronic health condition requiring on-going care (Please List)

Health Issues Questions:

Health Risks? □ Yes □ No □ Decline to Report
Chronic Illness? □ Yes □ No □ Decline to Report
Visit/check-up with PCP in the past 12 months? □ Yes □ No □ Decline to Report
Regular preventative health screens? □ Yes □ No □ Decline to Report

Revised 7/2007